

December 27, 2011

Ms. Marlene H. Dortch  
Secretary  
Federal Communications Commission  
445 12th Street SW  
Washington, DC 20554

Re: Notice of *Ex Parte* Communication, WC Docket No. 02-60

Dear Ms. Dortch:

On December 8, 2011, Terry Hill (Executive Director), Joe Wivoda (Chief Information Officer and HIT Consultant), Sally Trnka (Program Coordinator II), Tracy Morton (Program Manager), and Kate Stenehjem (Information Specialist), all of the National Rural Health Resources Center (NRHRC), spoke via telephone with Linda Oliver, Christianna Barnhart, and Chin Yoo of the Wireline Competition Bureau. The purpose of the meeting was to discuss the telecommunications needs of rural health care providers in response to the Commission's July 15, 2010 Notice of Proposed Rulemaking in the above-referenced docket. The parties discussed the following topics:

*Number of non-profit rural health care providers nationwide.* NRHRC estimated that there are approximately 3,800 rural health clinics funded by the U.S. Department of Health and Human Services (HHS). Of these, approximately one half are provider-based (*i.e.* associated with small rural hospitals or critical access hospitals), and one-half are independent (often run by physicians on a for-profit basis). Because nearly all small rural hospitals and critical access hospitals tend to be not-for-profit, NRHRC estimated that there are close to 1900 to 2000 provider-based clinics that are non-profit and thus would qualify for the FCC's rural health care program. NRHRC also estimated that over 90 percent of critical access hospitals nationwide are not-for-profit.

*Broadband needs for health IT.* Regarding broadband availability generally, NRHRC staff noted that the availability of adequate speeds and affordability are still issues with many rural health care providers.

With respect to electronic health records, NRHRC staff noted that the amount of bandwidth needed to implement electronic health records (EHRs) can range widely depending on how an EHR system is implemented. NRHRC staff noted that there was a vendor trend toward providing EHR systems in a software-as-a-service (SaaS) form, which requires sufficient bandwidth to connect to servers and run software over the network.

The staff noted that rural health care providers may not be capable of meeting EHR meaningful use requirements if adequate broadband capacity is not available. Due to the current shortage in the health IT workforce, vendors are short staffed and are conducting much of the training for implementation of EHR systems remotely over videoconference links. In order to access such training, health care providers need at least a 5 Mbps connection. Furthermore, NRHRC staff stated that the minimum level of broadband needed to meet health care needs is more than the minimum amount required for meaningful use. The staff expressed the opinion that health care providers need capacity above a T-1 line to *effectively* use EHRs (rather than just meeting meaningful use requirements). In addition, "going live" with electronic health records opens the door for health care providers to begin implementing telemedicine and other health IT applications.

With respect to telemedicine, NRHRC staff noted that bandwidth requirements can vary widely depending on specialty, ranging from telepsychiatry (on the lower end) to teledermatology (which can

involve transmission of large, high resolution images). The staff also noted that even where the bandwidth requirement for an individual application is low, using several applications at a single facility creates a cumulative effect requiring a lot of bandwidth. The staff also noted a trend toward using cloud-based services, which further increases bandwidth requirements.

NRHRC staff also expressed the opinion that telemedicine applications will be crucial in helping to address current and projected shortages in primary care and rural physicians nationwide, as well as shortages of pharmacists in rural areas. They noted that primary care physicians are the lifeblood of rural hospitals, and health care reform legislation has put additional demands on these physicians. The staff anticipates that telehealth applications will become increasingly useful and necessary for delivering primary care in rural communities (*e.g.* virtual exam rooms).

The NRHRC and FCC staff also discussed the attached survey of rural hospital broadband capabilities, as well as other surveys of rural health care provider health IT capabilities.

*Rural health care providers' ability to afford broadband.* NRHRC staff discussed the financial challenges faced by critical access hospitals and small rural hospitals today. Many such hospitals are experiencing negative margins and facing increasing difficulties in accessing capital. The staff noted that the person with responsibility for broadband purchasing decisions is likely under constant pressure to minimize expenses. The staff also noted that broadband has incremental price steps (for example, two bonded T-1s will cost twice as much as a single T-1 line), which encourages hospitals to purchase the minimum connectivity that is feasible. The NRHRC staff discussed the work that it is doing with rural health networks to encourage rural HCPs to conduct strategic planning about long-range needs, including health IT needs.

The staff also noted that the lack of reimbursement is the biggest obstacle to the deployment of telemedicine services. For example, where bandwidth is available, teleradiology services are common (despite large bandwidth requirements) because reimbursement is available for such services.

*Benefits of health IT.* NRHRC staff noted that health IT can help rural hospitals, including critical access hospitals, to provide care for rural residents in their local communities. The staff stated that most overtreatment, which accounts for one-third of national spending on health care, takes place in major health care centers rather than small rural hospitals. Thus, rural hospitals can provide care for less cost than urban hospitals. Having more rural patients receive care locally, in turn, helps rural hospitals to be successful.

*Use of the FCC's rural health care program.* The participants also discussed the challenges faced by rural health care providers in accessing rural health care program discounts, including learning the application process, the time gap from initial application to receipt of discounts, and the turnover in rural health care provider administrative personnel. The participants also noted that many rural health care providers are members of existing provider networks, and that allowing those networks to apply for support from the FCC's rural health care program on behalf of their members could be an efficient way to address those challenges. NRHRC staff also suggested that the FCC should continue to publicize the program to rural health providers and networks.

Respectfully submitted,

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Chin Yoo

Attorney Advisor, Telecommunications Access Policy Division, Wireline Competition Bureau

*Attachments:*

Results from the Rural Broadband Capabilities Survey  
Health IT in Rural America: Taking Charge of Change  
National Rural Health Information Technology Workforce Summit Summary  
List of awarded Rural Health Information Technology Network Development Grantees  
US Healthcare Workforce Shortages: HIT Staff  
Health IT-enabled Care for Underserved Populations: The Role of Nursing  
Tacking the Health I.T. Workforce Shortage